

**Pre-Application Technical Assistance Reports for the  
Access to Recovery Grant Program**

**Report on Technical Assistance to Wisconsin**

May 2004

***Prepared under***

Center for Substance Abuse Treatment  
Contract No. 277-00-6400, Task Order No. 277-00-6403

***By***

The Performance Partnership Grant  
Technical Assistance Coordinating Center



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Substance Abuse and Mental Health Services Administration  
Center for Substance Abuse Treatment  
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## **Consultation between Barry Brauth and the State of Wisconsin Written Report**

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### **Introduction (Purpose of TA)**

The State of Wisconsin (the State) requested assistance in assessing the role that financial incentives could play in their planned voucher proposal for the Access to Recovery (ATR) grant program. Johnson, Bassin & Shaw, Inc. (JBS) contacted Barry Brauth of New York State's Office of Mental Health to assist the State.

### **Methodology**

On May 3, 2004, the consultant, Barry Brauth, conducted a telephone conference with representatives from the State of Wisconsin, Milwaukee county, and Metahouse, a women and children's provider which was contracted to lead the drafting of the proposal. Participants on the call included Jim Beer and his executive director, Francine Feinberg, from Metahouse, as well as David Jebb, Paul Rodomski, and Virgil Williams from Wisconsin and Milwaukee. The call lasted approximately 1 hour. The consultant conducted subsequent phone calls and e-mails with Jim Beer over the next week. (For the background and experience of the consultant, see the last section of this report.)

### **Content of TA Discussion**

The State provided a brief overview of highlights of Wisconsin's current delivery system and their thinking about modifications to make it ATR-compatible. Wisconsin indicated that they are thinking about implementing ATR in Milwaukee County. In Wisconsin, the counties are responsible for operating substance abuse services out of funds allocated to them from the State. Milwaukee County already has a voucher system that pays for treatment services. The county hopes to use the ATR money to expand the network and fund recovery support services. They now contract with residential providers using fee for service but have a voucher system for their outpatient services.

**Wisconsin:** The Wisconsin team indicated that they were highly motivated to include financial incentives in their program, but they were unsure how to proceed. The team knew that clients would be receiving services from several different providers, all of whom would be unaffiliated with each other. Therefore, outcomes could not easily be tracked back to any individual provider.

**Consultant:** Mr. Brauth discussed several ways in which incentives could be used, including the following:

- How incentives could be used with the case management organization to keep services within budget
- How incentives for treatment providers could encourage them to refer clients to recovery support providers
- How incentives could be provided for recovery support and for everyone else involved in services to the client by allocating an incentive based on the client's overall outcomes

Mr. Brauth consulted with Wisconsin on several occasions, including a 1-hour conference call on May 3, telephone calls on May 5, 6, and 12, and e-mails on May 5 and 13. These back and forth contacts, as well as feedback received from other States, was the laboratory for developing the consultant's final recommendations.

## **Recommendations**

***Provider incentives related to client outcomes.*** The consultant suggested that Wisconsin track the outcomes of clients across the seven domains and create one single overall score for each client. Providers would either meet or miss the State's outcome target. If providers meet the target, they would be eligible for an incentive payment.

***Incentives as a cost-of-living adjustment over time.*** Incentive payments could be applied as a cost-of-living adjustment (COLA) to the provider's rate for the next year. If, based on their first year's performance data, the provider has met their minimum outcome standards, they would receive a 3 percent incentive increase on their second year's rates. If providers again meet their performance targets in the second year, an additional 3 percent would be added on their third year's rates. Using this method, incentives would be a vehicle for funding annual COLA adjustments for those providers that successfully produce outcomes. Mr. Brauth suggested that, in the second and third years of the grant, the State might want to either freeze the base rates or decrease the base rates by a couple of percentage points each year, adding that amount to the incentive payment.

In this way, the State can build in both "a carrot and a stick" for good performance. This incentive plan could move the system incrementally in the direction of paying for outcomes rather than for services. This plan would also create a mechanism for gaining the "buy-in" and commitment of State budget offices and legislatures, as a result of building the COLA into substance abuse treatment rates.

## **Consultant's Background**

Barry Brauth has worked for more than 25 years in various positions in administering both medical and behavioral health programs. After receiving his Master's degree in public administration, Mr. Brauth moved to Albany for a position as a Federal Programs Coordinator for the State Office of Mental Health (OMH). There he developed rate and reimbursement strategies that resulted in hundreds of millions of dollars in increased Medicare and Medicaid revenue for New York State mental health programs.

In the early 1980s, Mr. Brauth joined Blue Cross of Northeastern New York as the senior policy advisor to the President. There he designed client tracking systems which were used to profile providers and to develop innovative insurance and funding mechanisms, such as case payment and prudent purchasing arrangements.

Mr. Brauth has worked with the OMH since 1986, except for a 1-year period as director of Utilization and Data Analysis with Value Behavioral Health. His responsibilities with OMH have included development of a patient classification schema and rate setting alternative to the Medicare psychiatric Diagnostic Related Groupings (DRGs). This alternative rate-setting methodology reimbursed hospitals based on case mix, length of stay, recidivism, and linkage to outpatient services. The project required the development of a sophisticated client information system, which was later used for planning, utilization monitoring, and the development of managed care proposals.

Mr. Brauth's current position is Director of Financial Planning. He is responsible for developing fiscal initiatives and reimbursement methodologies, which promote mental health programs that are stable, accountable, and outcome oriented.